Auto-Auth Guidelines

The following information will help insure that more authorizations get initial approval by the Auto-Auto program.

Fund Control Number:

You must select a fund control number 4050 State Clients or 4003 Medicaid Clients
A client is considered an adult when they turn 21 for Medicaid funding.
A client is considered an adult when they turn 18 for State funding.

MEDICAID FUNDED CLIENTS

Fund Control	Description	Age
4003	Medicaid - Adult	21 and over
4003	Medicaid - Child	Under 21

STATE FUNDED CLIENTS - Adult

Fund Control	Description	Age
4050	Adult MH	18 and over
4050	Adult DD	18 and over
4050	Adult SA	18 and over
4050	Adult MR/MI	18 and over
4050	Adult Dev. Thy.	18 and over

STATE FUNDED CLIENTS – Child

Fund Control	Description	Age
4050	Child MH	Under 18
4050	Child DD	Under 18
4050	Child SA	Under 18
4050	Child CMSED / CTSP	Under 18
4050	Child Dev. Thy.	Under 18

AGENCY OR STAFF AUTHORIZATIONS:

Select Provider ID that ends in 001 for an agency authorization – this will allow any staff that is qualified to perform the service to submit billing.

If the request is for a specific staff, then only that staff can submit billing. If the client changes staff, a new authorization would need to be entered.

Authorizations that are issued by Value Options for staff that will be billed by the LME will be staff specific and entered by the LME Contract Management staff.

SERVICE CATEGORIES:

The drop-down list of service categories, are based on services that are allowed for the Provider ID selected.

State billing codes have been added to your drop down list.

We are in the process of removing our in-house billing service categories. You must select the CPT, H, or Y codes when requesting individual services. Once we finish the conversion you will not see our in-house codes.

DO NOT SELECT ANY OF OUR IN-HOUSE CODE (i.e. 10, 11,12 etc.).

PACKAGES:

Several packages of services have been setup to allow some flexibility in providing services for outpatient and evaluations. You can view a list of services that are in the packages using Menu Option 8.

Medicaid allows clients 26 visits if the client is under 21 and 8 visits if they are over 21 each calendar year. You are not required to get an authorization for direct enrolled staff, if the service is Medicaid funded.

MEDICAID PACKAGES – INITIAL CALENDAR YEAR VISITS

UNMANAGED VISITS

Package	Description	Direct Enrolled	Non-Direct Enrolled
4003UMMH	Unmanaged MH Outpatient	Auth Not Required	LME Auth Required
4003UMSA	Unmanaged SA Outpatient	Auth Not Required	LME Auth Required

MEDICAID PACKAGES – AFTER INITIAL CALENDAR YEAR VISITS

Package	Description	Direct Enrolled	Non-Direct Enrolled
4003MHOT	Managed MH Outpatient	Authorized by Value Options – Will NOT be entered into the MCO	Authorized by Value Options – Will be entered into the MCO by LME Contract Dept. staff
4003SAOT	Managed SA Outpatient	Authorized by Value Options – Will NOT be entered into the MCO	Authorized by Value Options – Will be entered into the MCO by LME Contract Dept. staff

STATE PACKAGES July 1 – June 30 Year:

Package	Description	Direct Enrolled	Non-Direct Enrolled
4050MHOT	STATE CLIENTS	LME Auth Required	LME Auth Required
4050SAOT	STATE CLIENTS	LME Auth Required	LME Auth Required

TARGET POP:

Refer to the State Service Array for the target pop that will pay for the service requested.

The client must be enrolled in the target pop that you select.

DISPLAYING THE LME CLIENT INFORMATION WILL HELP IN SELECTION THE TARGET POP AND REQUEST DATE RANGE.

THINGS TO CHECK TO HELP PASS THE AUTO-AUTH EDITS:

1. **Is the client currently enrolled in the target pop selected?**

2. **Is the service billable under the target pop selected?**

3. **Is the date range of the authorization request covered by the client's enrollment in the target pop? You may want to shorten the end date of the request so the request will pass the auto-auth edits.**

4. **Only request the number of units that are medically necessary.**

5. **Check the Procedure Database to see the maximum number of hours/events that are allowed. If the client needs a level of service that is greater than the maximum, supply the reason for the additional units, so that the UM staff may make a judgment on the medical necessity of the request.**

6. **Check the Procedure Database to see the maximum day that is allowed between reviews.**

7. **Make sure that the authorization request does not end after the clients current treatment plan.**

8. **Make sure that request for State services do not cross over two State years. The authorization cannot go pass June 30.**

9. **If a new service is being requested for the client, add justification that will help UM make a decision on the medical necessity of the request.**